Notice of Adverse Benefit Determination For Beneficiaries of Medicaid Programs
Kalamazoo Community Mental Health and Substance Abuse Services (KCMHSAS)

Name: ______________________ ID# ______________

Guardian/Parent (as applicable) ______________________ Date: ______________

Kalamazoo Community Mental Health and Substance Abuse Services (KCMHSAS) has made the following determination(s) about the service(s) you have asked for or the service(s) you currently get from us. This does **not** mean that you will lose your Medicaid Benefits and will not affect any other services you are getting, or may need in the future.

The Determination we have made is:	Name of Service(s) Affected	Date
☐ Service(s) Authorized		
☐ Limited Service Authorization (less than requested)		
☐ Undue Service Delay (over 14 days from agreed start date)		
☐ Failure to provide timely authorization decision / Notice		
☐ Service(s) Denied: ☐ At time of application/intake ☐ Requested Inpatient service ☐ Services in addition to Plan		
☐ Other: *Define*		

	Name of Service(s) Affected	Effective Date
☐ Reduction in current services		
☐ Suspension of current services		
☐ Termination of current services		

If your services were denied, delayed, reduced, suspended, or terminated it is because:

☐ **At this time, you do not meet the clinical eligibility criteria for specialty mental health or substance abuse services.** Your current presentation is above what would qualify you for services as a person with a serious mental illness, or a developmental disability, or a substance use disorder, or a child with a serious emotional disorder.

☐ **Lack of Medical Necessity.** It has been determined that the service(s) identified in this notice are not: clinically appropriate, or necessary to meet your needs; or consistent with your diagnosis, symptoms or impairments; or the most cost effective option in the least restrictive environment; or consistent with current/clinical standards of care.

☐ **You have other resources available that will provide payment for service(s):** ______________

☐ **Residency.** You live outside of our service area. We cannot authorize on-going/non-emergency services for you.

☐ **Residency.** You are currently residing in an institution in which KCMHSAS cannot authorize your services. (e.g. jail, prison, state hospital, extended care facility)

☐ **Your Individual Plan of Service goals and objectives have been met**.

☐ **Lack of Participation.** KCMHSAS cannot continue to authorize services for you if you are not participating. You have not attended or participated in your authorized services since (date): ______________

☐ **Lack of Capacity to Benefit.** It has been determined that the service(s) identified in this notice have been provided but are not significantly successful helping you: make substantial gains; meet the goals/objectives in your Plan of Service; recover from your symptoms; or improve your daily functioning skills/ability to care for yourself.

☐ **You have requested the action to occur**. See Signature area below for notes.

☐ **Other:** ______________

The legal basis for notice of this determination is 42 CFR 440.230(d) and applicable policy found in the Michigan Medicaid Provider Manual: Behavioral Health and Intellectual & Developmental Disability Supports and Services
The second page has more information about accessing information regarding the reasons for this determination.
IF YOU DO NOT AGREE WITH THIS DETERMINATION, PLEASE READ *YOUR RIGHTS* ON PAGE TWO (2).

______________ ______
Individual/Guardian Signature (as applicable) Date

Note: Signature of the Individual Served/Guardian is not required and does not mean agreement with the action, unless the action was initiated by the individual.

______________ ______ ______________ ______
Staff Signature/ Credential Date Approving Signature (as necessary) Date

Notice provided: ☐ via mail ☐ in person

Notice copied to: ☐ Provider ☐ Access

If you do not understand any part of this Benefit Determination, or need help with any of the appeal processes below, please call KCMHSAS at (269) 553-7000 or 1-877-553-7160.
All persons who are deaf or hard-of-hearing please contact us using the Michigan Relay Center.
Dial 7-1-1 and give (tell) MRC the number you are trying to reach.
Other language accommodations can also be arranged by contacting Customer Services.

Your Rights: If you are not happy with this determination, you may:

- Ask to review your services/plan with your primary clinician or their supervisor; and/or
- Contact the KCMHSAS Recipient Rights Office by calling (269) 364-6920; and/or
- Request a **Local Appeal** within 60 calendar days of the date of this Determination; Details below
- If you were denied initial access/entry to all KCMHSAS services or were denied inpatient psychiatric hospitalization services, you can request a Second Opinion of that decision.

To request a Second Opinion, please contact KCMHSAS at (269) 553-7000 or 1-877-553-7160.

You also have the right to request and receive free copies of all of the documents/information from your records, and copies of KCMHSAS criteria and policies that are relevant to how this benefit determination was made.

You may choose to have another person represent you in exercising your rights – as your Authorized Representative. This person may be your legal counsel (attorney), a relative, a friend, or another spokesperson. Both you and your representative must sign and date a statement confirming this is what you want. If you have questions or need assistance about his process, please contact Customer Services.

Requesting a Local Appeal: If you do not agree with this determination, you or your Authorized Representative may request a Local Appeal. Your request can be made orally or in writing and must be received by KCMHSAS within 60 calendar days of the date at the top of this Notice of Adverse Benefit Determination document.
Mail: KCMHSAS Customer Services | 2030 Portage Street | Kalamazoo, MI 49001
Phone: (269) 553-7000 or toll free 1-877-553-7160

You can expect your appeal to be resolved within 30 calendar days from the day you request it. Your written Resolution Letter will tell you the next steps you are not satisfied with the resolution.

You have a right to an Expedited Local Appeal Resolution if you believe that waiting the standard time (up to 30 calendar days) for resolution would seriously jeopardize your life or health or your ability to attain, maintain or regain maximum function. To request an expedited appeal, you must call KCMHSAS Customer Services. Based on our assessment of your request, if we grant this request, your Resolution will be made within 72 hours. If we do not grant you an expedited resolution, we will inform you as soon as possible and discuss the reason with you.

When you file your appeal, please give us your reason for appealing. You can also provide us with any evidence or other information (medical records, or other supporting documents) that you feel helps to explain why you need the service(s).

Continuing Services: If this determination is reducing, suspending, or terminating any service(s) you are currently receiving, you may ask that your services remain in place during the appeal process if: (1) you appeal prior to the Effective Date of the change in your services as stated on page 1 of this Notice of Adverse Benefit Determination; and (2) you request that services continue; and (3) the authorization/approval for the service(s) has not already expired.

Reasons for this Benefit Determination: The Michigan Medicaid Provider Manual – Chapter: Behavioral health and Intellectual & Developmental Disability Supports and Services - sets the policies/rules and provides guidance to agencies like KCMHSAS that provide Mental Health and Substance Abuse services. If you want to review the manual, you can find it at www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf. You can also contact Customer Services at KCMHSAS at (269) 553-7000 or 1-877-553-7160 for more information about the Manual and the reasons why this benefit determination was made.

* Emergency services remain available to you at all times by calling 269-373-6000 or 1-888-373-6200. *